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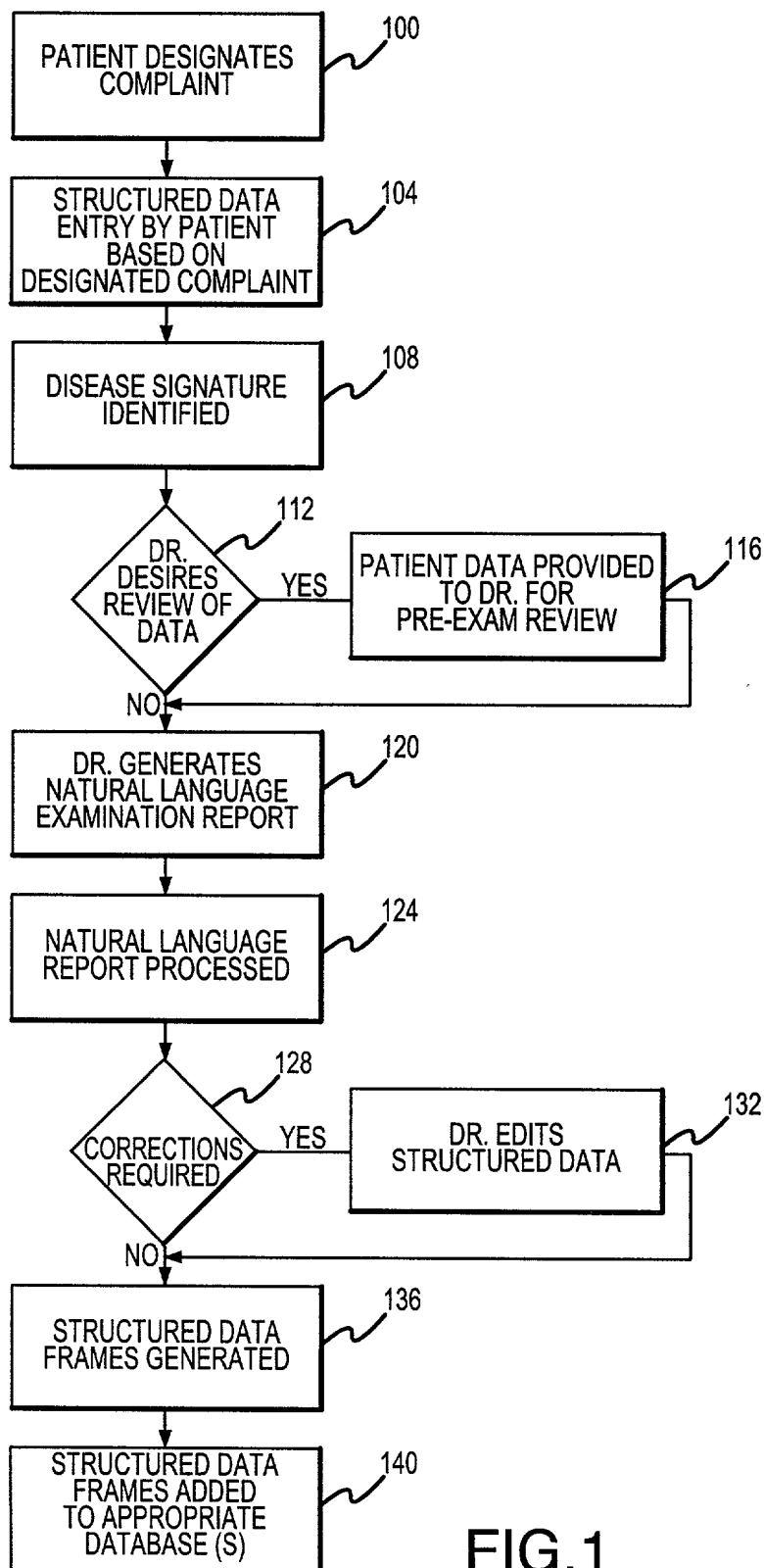


FIG.1



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PATIENT ID: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ PROCEDURE ID: \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT INFORMATION

NAME

ADDRESS

HOME PHONE

WORK PHONE

E-MAIL

GENDER ☐ MALE ☐ FEMALE

BIRTH DATE  MONTH  DAY  YEAR

RACE/ETHNICITY  
☐ WHITE/CAUCASIAN ☐ AFRICAN AMERICAN ☐ HISPANIC/LATINO  
☐ ASIAN/PACIFIC ISLANDER ☐ NATIVE AMERICAN ☐ MULTIRACIAL  
☐ OTHER

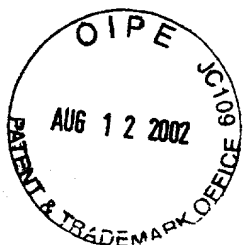
MARITAL STATUS  
☐ SINGLE ☐ LIVING WITH ANOTHER ☐ MARRIED  
☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

EDUCATION LEVEL  
☐ HIGH SCHOOL OR LESS ☐ VOCATIONAL/TECHNICAL ☐ COLLEGE DEGREE  
☐ GRADUATE DEGREE ☐ PROFESSIONAL DEGREE

OCCUPATIONAL STATUS  
☐ EMPLOYED ☐ STUDENT ☐ RETIRED  
☐ UNEMPLOYED

INSURANCE/BILLING  1.  2.

FIG.2



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PATIENT ID: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ PROCEDURE ID: \_\_\_\_\_ DATE: \_\_\_\_\_

REASON FOR VISIT ☐ ROUTINE (E.G., CHECKUP) ☐ 1<sup>ST</sup> VISIT TO THIS PHYSICIAN, OR NEW MEDICAL CONDITION ☐ FOLLOW-UP FOR EXISTING MEDICAL CONDITION

REFERRED BY: ☐ PRIMARY CARE PHYSICIAN ☐ ANOTHER SPECIALIST ☐ SELF

REFERRING DIAGNOSIS \_\_\_\_\_

ICD - 9 CODES  
1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

PHENOMENON CATEGORY ☐ LUMP/BUMP ☐ DISCHARGE/LEAK ☐ BLEEDING  
☐ WRONG DIRECTION ☐ DISCOLORATION ☐ INTAKE DIFFICULTY

OTHER PHENOMENON CATEGORY \_\_\_\_\_

IF YOU ARE EXPERIENCING A NEW MEDICAL PROBLEM, SYMPTOM, OR CONDITION, PLEASE FILL OUT THE FOLLOWING:

CHIEF COMPLAINT \_\_\_\_\_

SYMPTOM DURATION

SYMPTOM QUANTITY  
(DISEASE-SPECIFIC)

SYMPTOM TIMING  
(DISEASE-SPECIFIC)

SYMPTOM CONTEXT

SYMPTOM QUALITY

RELEVANT PAST HX

PREVIOUS CONSULT WITH ANOTHER PHYSICIAN ☐ YES ☐ NO

RECEIVED MEDICAL TREATMENT FOR THIS CONDITION ☐ YES ☐ NO

PREVIOUS SURGERY FOR THIS CONDITION ☐ YES ☐ NO

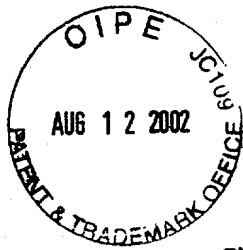
OTHER \_\_\_\_\_

RELEVANT FAMILY HX (DISEASE-SPECIFIC) \_\_\_\_\_

IF THIS IS A FOLLOW-UP VISIT, PLEASE ANSWER THE FOLLOWING:

SYMPTOM EVOLUTION (PER SYMPTOM) ☐ GONE AWAY COMPLETELY ☐ IMPROVED ☐ NO CHANGE  
☐ WORSE

FIG.3



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PATIENT ID: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ PROCEDURE ID: \_\_\_\_\_ DATE: \_\_\_\_\_

ARE YOU EXPERIENCING ANY OF THE FOLLOWING PROBLEMS?	<input type="checkbox"/> WEIGHT LOSS <input type="checkbox"/> WEIGHT GAIN	<input type="checkbox"/> FEVER	<input type="checkbox"/> FATIGUE	CONSTITUTIONAL
DO YOU HAVE LAZY EYE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		EYE PROBLEMS
ANY NEW VISION/EYE PROBLEMS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
IF YES, PLEASE CHECK...	<input type="checkbox"/> BLURRED VISION <input type="checkbox"/> EYE PAIN	<input type="checkbox"/> DOUBLE VISION <input type="checkbox"/> EYE REDNESS	<input type="checkbox"/> LOSS OF VISION <input type="checkbox"/> EYE DRYNESS	
ARE YOU HAVING HEARING, BALANCE, SPEECH OR THROAT PROBLEMS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		EAR/NOSE/THROAT
IF YES, PLEASE CHECK...	<input type="checkbox"/> TROUBLE HEARING <input type="checkbox"/> LOSS OF BALANCE <input type="checkbox"/> HOARSENESS	<input type="checkbox"/> RINGING IN EAR(S) <input type="checkbox"/> EAR PAIN <input type="checkbox"/> TROUBLE SWALLOWING	<input type="checkbox"/> DIZZINESS <input type="checkbox"/> EAR DISCHARGE <input type="checkbox"/> SLURRED SPEECH	
HAVE YOU BEEN TOLD YOU HAVE A HEART MURMUR?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		CARDIOVASCULAR
ARE YOU EXPERIENCING ANY CHEST PAIN, HEART PROBLEMS, LIMB PAIN, OR FAINTING?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
IF YES, PLEASE CHECK...	<input type="checkbox"/> CHEST PAIN <input type="checkbox"/> FAINTING	<input type="checkbox"/> LIMB SWELLING <input type="checkbox"/> LIMB PAIN ON WALKING	<input type="checkbox"/> FAST HEART BEAT <input type="checkbox"/> IRREGULAR HEART BEAT	
DO YOU HAVE ASTHMA?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		RESPIRATORY
ARE YOU HAVING PROBLEMS BREATHING, COUGHING, OR COUGHING UP ANYTHING?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
IF YES, PLEASE CHECK...	<input type="checkbox"/> TROUBLE BREATHING <input type="checkbox"/> YES	<input type="checkbox"/> CHRONIC COUGH <input type="checkbox"/> NO	<input type="checkbox"/> COUGHING BLOOD	
ARE YOU HAVING ANY STOMACH OR DIGESTIVE PROBLEMS?	<input type="checkbox"/> YES			GASTROINTESTINAL
IF YES, PLEASE CHECK...	<input type="checkbox"/> INDIGESTION <input type="checkbox"/> NAUSEA <input type="checkbox"/> DIARRHEA	<input type="checkbox"/> HEART BURN <input type="checkbox"/> VOMITING <input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> ABDOMINAL PAIN <input type="checkbox"/> REGURGITATION <input type="checkbox"/> BLOODY STOOLS	

FIG.4

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ARE YOU HAVING ANY PROBLEMS URINATING?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	GENITOURINARY	
IF YES, PLEASE CHECK...	<input type="checkbox"/> INCONTINENCE <input type="checkbox"/> EXCESSIVE URINATION	<input type="checkbox"/> PAIN ON URINATION	<input type="checkbox"/> BLOOD IN URINE	MUSCULOSKELETAL
ARE YOU HAVING MUSCLE OR JOINT PROBLEMS OR PAIN ANYWHERE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
IF YES, PLEASE CHECK...	<input type="checkbox"/> JOINT SWELLING <input type="checkbox"/> JOINT PAIN <input type="checkbox"/> JOINT STIFFNESS	<input type="checkbox"/> MUSCLE PAIN <input type="checkbox"/> MUSCLE CRAMP <input type="checkbox"/> MUSCLE TWITCHES	<input type="checkbox"/> BACK PAIN <input type="checkbox"/> NECK PAIN <input type="checkbox"/> LOSS OF MUSCLE	SKIN & BREAST
ARE THERE ANY CHANGES TO YOUR SKIN, HAIR, SENSE OF FEEL, OR SWEATING?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
IF YES, PLEASE CHECK...	<input type="checkbox"/> NUMBNESS <input type="checkbox"/> HAIR LOSS <input type="checkbox"/> SKIN RASH	<input type="checkbox"/> TINGLING <input type="checkbox"/> NAIL CHANGES <input type="checkbox"/> DRY EYES/MOUTH	<input type="checkbox"/> DISCOLORATION <input type="checkbox"/> SWEATING CHANGES	NEUROLOGIC
ARE YOU HAVING HEADACHES/ HEAD PAIN, BLACKOUTS, COORDINATION PROBLEMS OR MEMORY PROBLEMS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
IF YES, PLEASE CHECK...	<input type="checkbox"/> HEADACHE <input type="checkbox"/> WEAKNESS <input type="checkbox"/> BLACKOUTS	<input type="checkbox"/> FACE PAIN <input type="checkbox"/> TREMORS <input type="checkbox"/> TROUBLE WITH MEMORY	<input type="checkbox"/> FACE NUMBNESS <input type="checkbox"/> CLUMSINESS <input type="checkbox"/> TROUBLE CONCENTRATING	PSYCHIATRIC
ARE YOU HAVING ANY PSYCHOLOGICAL ISSUES OR PROBLEMS WITH SLEEP?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
IF YES, PLEASE CHECK...	<input type="checkbox"/> HALLUCINATIONS <input type="checkbox"/> SUICIDAL THOUGHTS	<input type="checkbox"/> FEELING DEPRESSED <input type="checkbox"/> INAPPROPRIATE CRYING	<input type="checkbox"/> TROUBLE SLEEPING <input type="checkbox"/> INAPPROPRIATE LAUGHING	HEMATOLOGIC/ LYMPHATIC
ARE YOU BLEEDING OR HAVE FOUND ANY LUMPS/SWELLING THAT ARE NEW?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> LUMPS OR SWELLINGS	ENDOCRINE
DO YOU HAVE ANY OF THE OTHER FOLLOWING SYMPTOMS?	<input type="checkbox"/> EXCESSIVE THIRST	<input type="checkbox"/> ABNORMAL BLEEDING <input type="checkbox"/> NOSE BLEEDS <input type="checkbox"/> HEAT/COLD INTOLERANCE		

FIG.5



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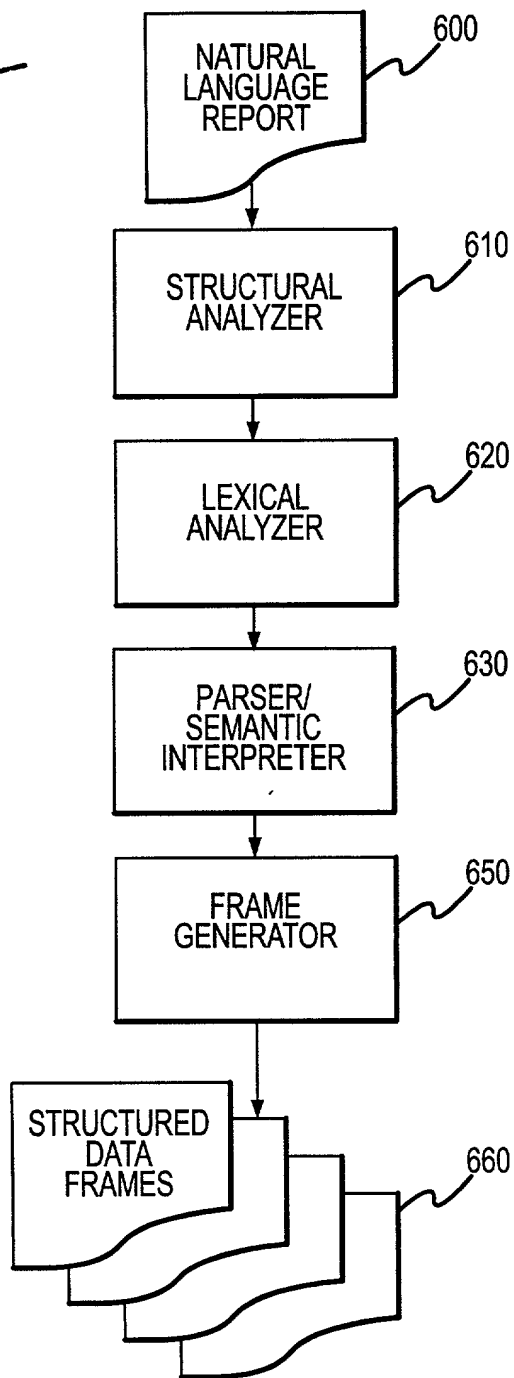


FIG.6



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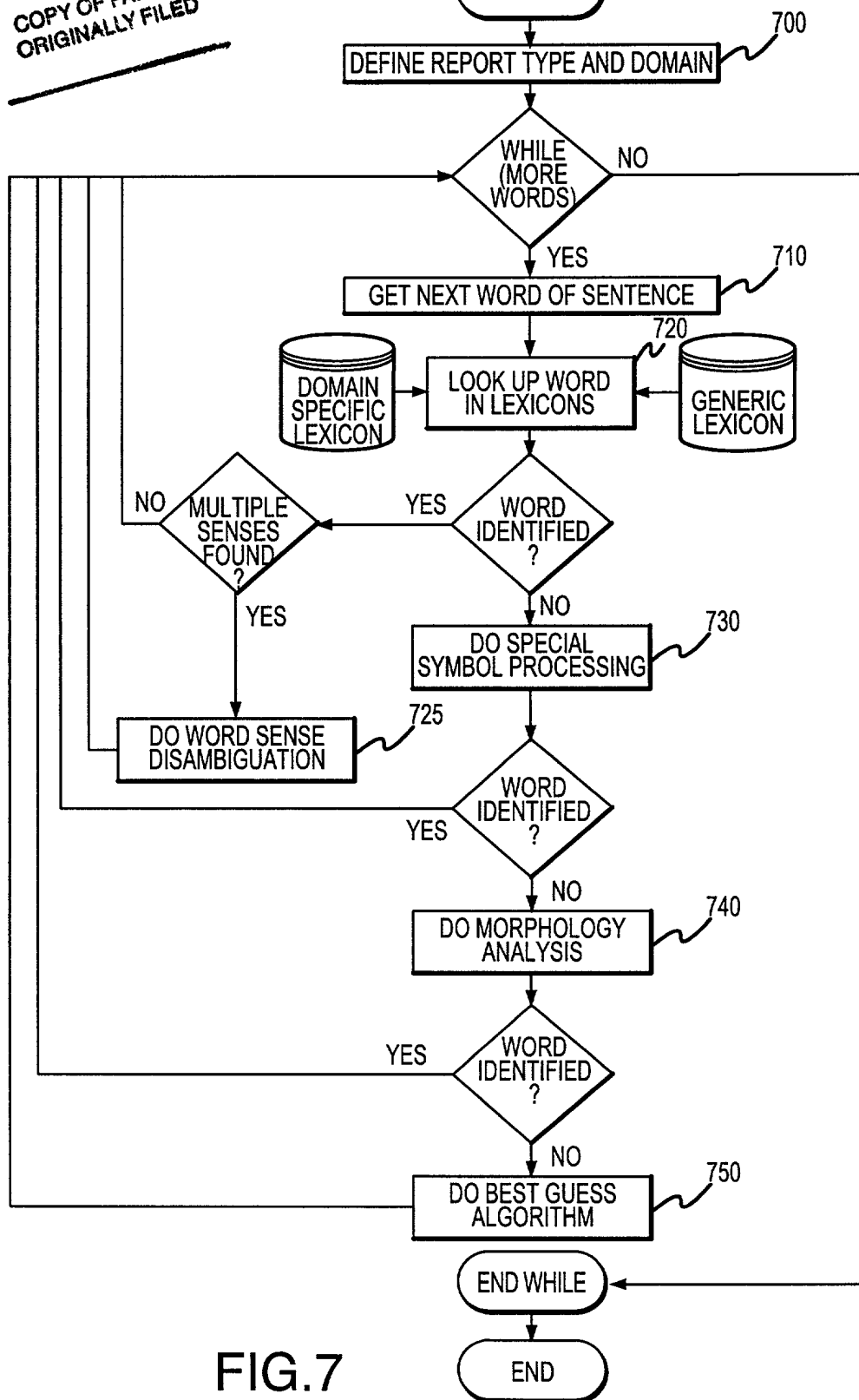


FIG.7



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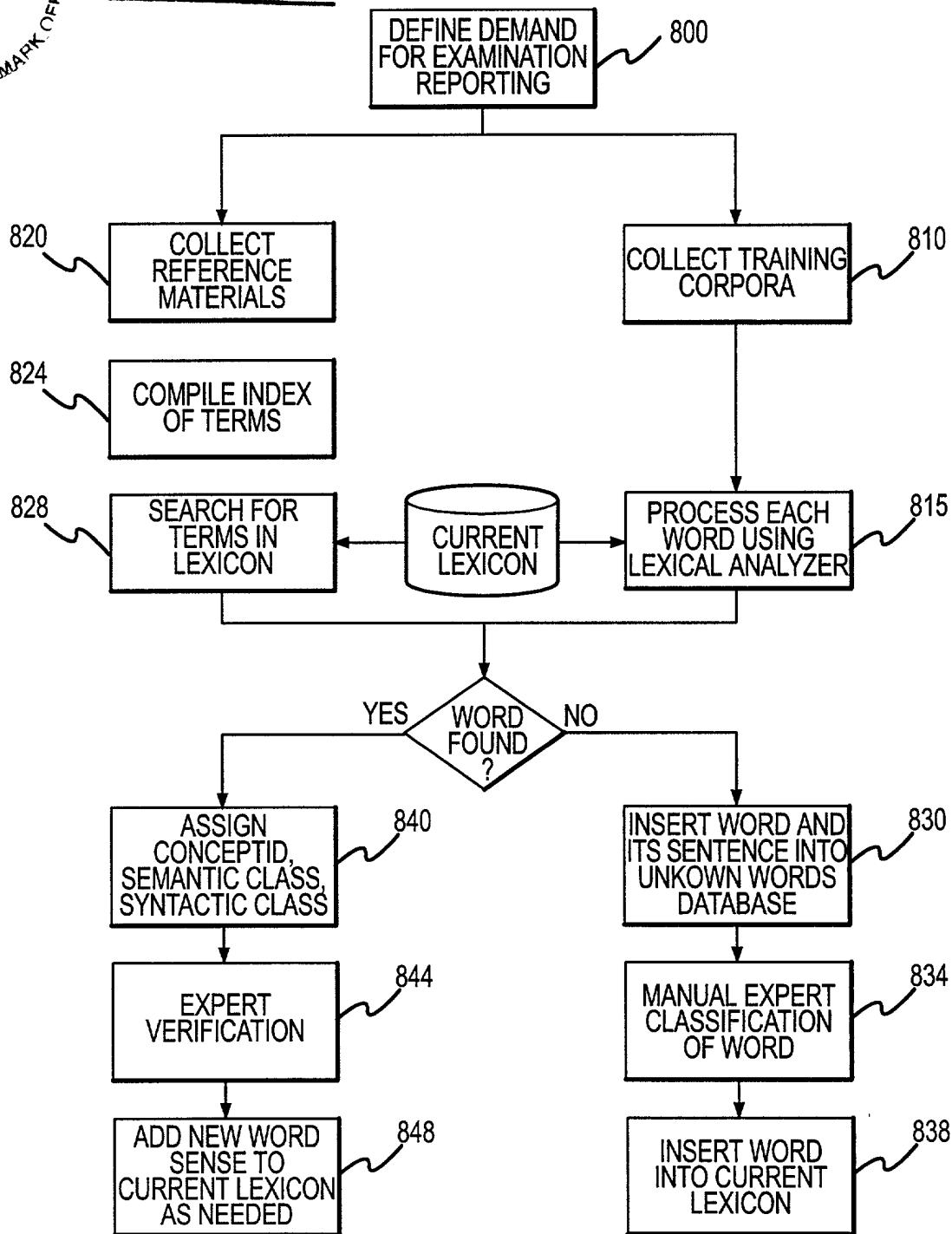


FIG.8





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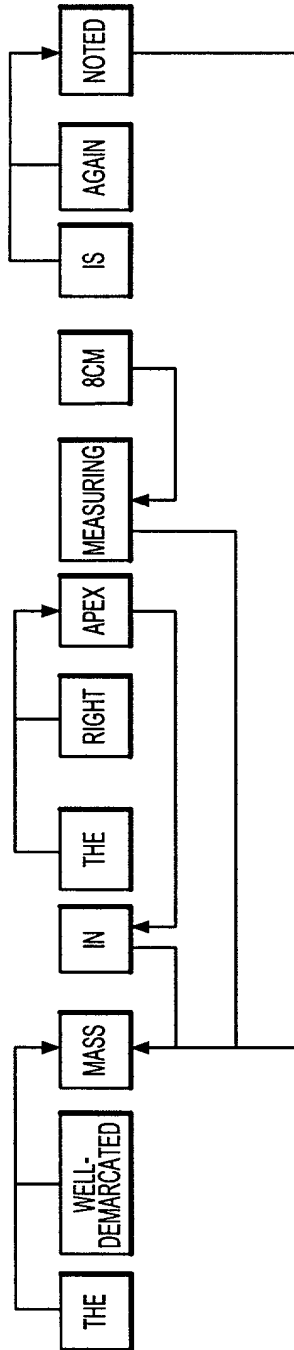


FIG.9A

predicate	head	relation	value
hasArticle	mass	EQUALS	the
hasBorderDef	mass	EQUALS	well-demarcated
hasLocation	mass	in	apex
hasDirection	apex	EQUALS	right
hasSize	mass	measuring	8cm
hasTempMod	noted	EQUALS	again
hasAuxillary	noted	EQUALS	is
hasExistence	mass	EQUALS	noted

FIG.9B



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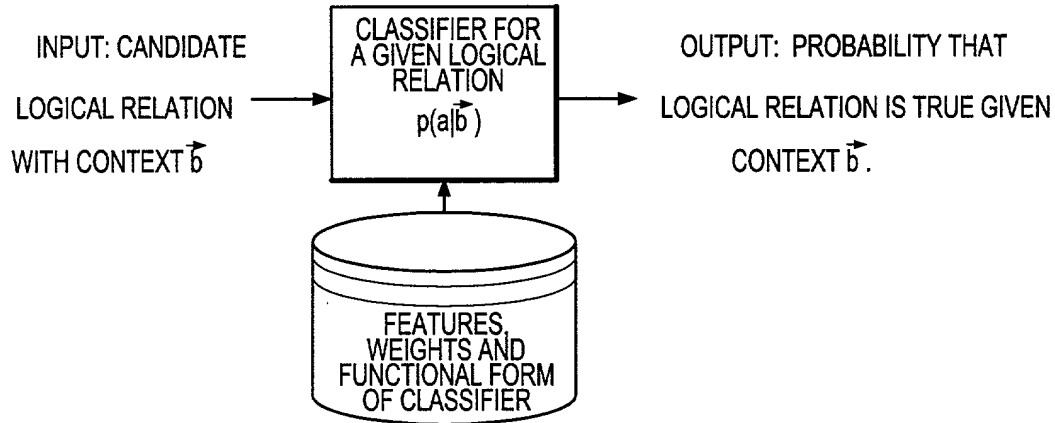


FIG.10A

MAXIMUM ENTROPY MODEL USED FOR PARSER/SEMANTIC INTERPRETER

$$p(a|\vec{b}) = \frac{1}{Z(\vec{b})} \cdot \exp \left\{ \sum_1^n \lambda_i f_i(a, \vec{b}) \right\}$$

$\lambda_i$  = WEIGHTING FACTOR FOR FEATURE  $i$  (COMPUTED FROM TRAINING EXAMPLE STATISTICS)

$Z(\vec{b})$  = NORMALIZATION FACTOR TO ASSURE THAT THE PROBABILITY IS WITHIN THE RANGE 0.0 TO 1.0

FIG.10B

- (i)  $f(a, \vec{b}) = \begin{cases} 1 & \text{if } (a=1) \text{ \& } (b_2=\text{TRUE} \text{ \& } b_6=\text{TRUE} \text{ \& } b_8 = \text{FALSE}) \\ 0 & \text{OTHERWISE} \end{cases}$
- (ii)  $f(a, \vec{b}) = \begin{cases} 1 & \text{if } (a=0) \text{ \& } (b_2=\text{FALSE} \text{ \& } b_1=\text{TRUE} \text{ \& } b_8=\text{TRUE}) \\ 0 & \text{OTHERWISE} \end{cases}$

FIG.10C



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	THE	OSSEUS	AND	SOFT TISSUE	STRUCTURES	OF	THORAX	DEMONSTRATE	CHANGE
THE	<input type="radio"/>			<input checked="" type="radio"/>	<input checked="" type="radio"/>		<input checked="" type="radio"/>		<input checked="" type="radio"/>
OSSEUS		<input type="radio"/>	<input checked="" type="radio"/>		<input checked="" type="radio"/>				<input checked="" type="radio"/>
AND			<input type="radio"/>	<input checked="" type="radio"/>					
SOFT TISSUE				<input type="radio"/>	<input checked="" type="radio"/>		<input checked="" type="radio"/>		<input checked="" type="radio"/>
STRUCTURES					<input type="radio"/>				
OF					<input checked="" type="radio"/>	<input type="radio"/>			
THORAX						<input checked="" type="radio"/>	<input type="radio"/>		
DEMONSTRATE				<input checked="" type="radio"/>	<input checked="" type="radio"/>		<input checked="" type="radio"/>	<input type="radio"/>	
CHANGE						<input checked="" type="radio"/>		<input checked="" type="radio"/>	<input type="radio"/>

FIG.11A



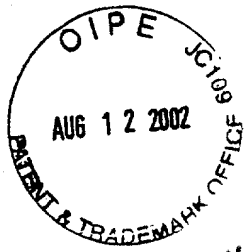
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	THE	OSSEUS	AND	SOFT TISSUE	STRUCTURES	OF	THORAX	DEMONSTRATE	CHANGE
THE	○			0.42	0.89		0.13		0.05
OSSEUS		○	0.78		0.74				0.28
AND			○	0.78			0.31		
SOFT TISSUE				○	0.91		0.42		0.31
STRUCTURES					○				
OF					0.95	○			
THORAX						0.95	○		
DEMONSTRATE				0.68	0.78		0.65	○	
CHANGE						0.29		0.92	○

FIG.11B

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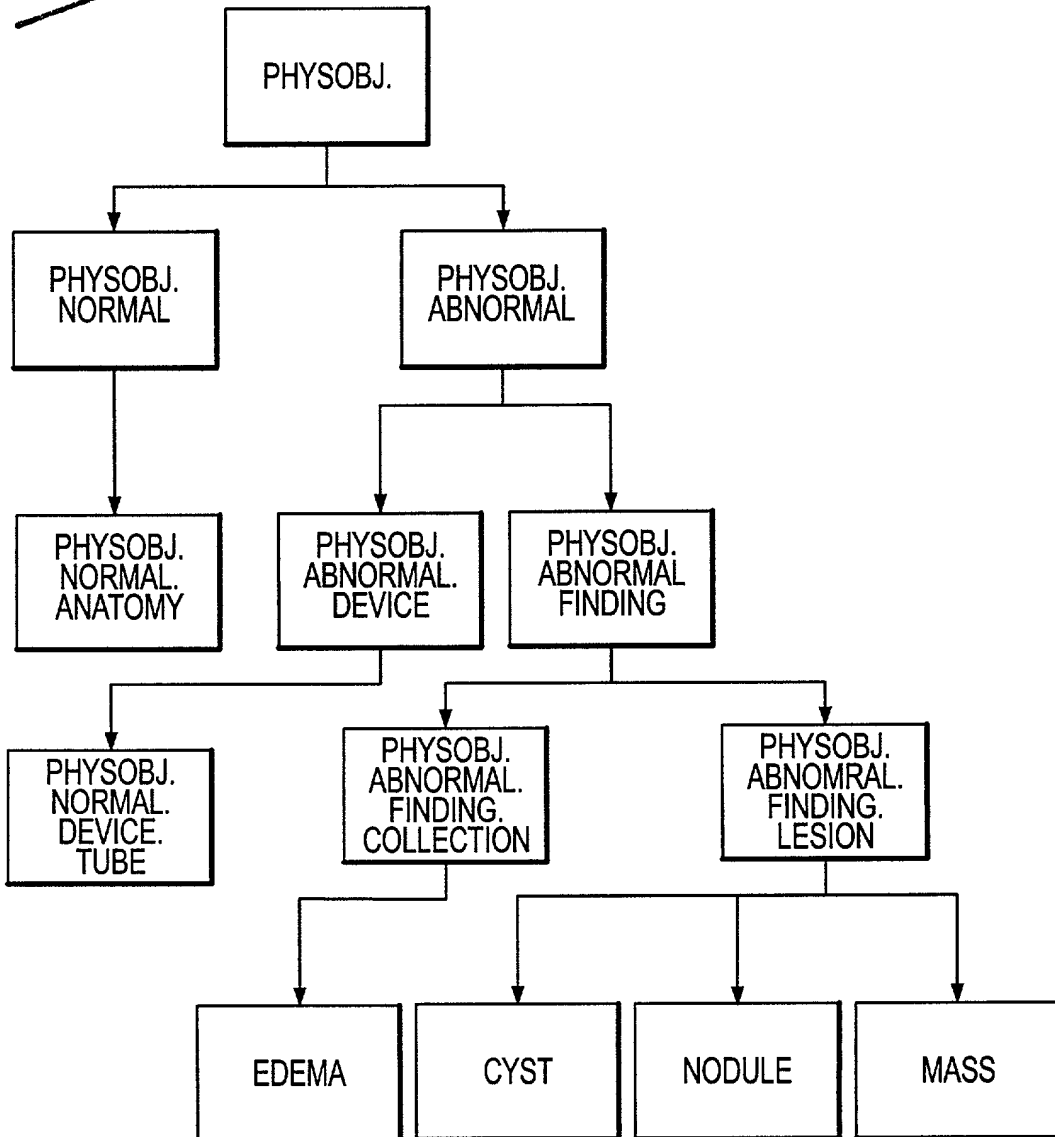


FIG.12



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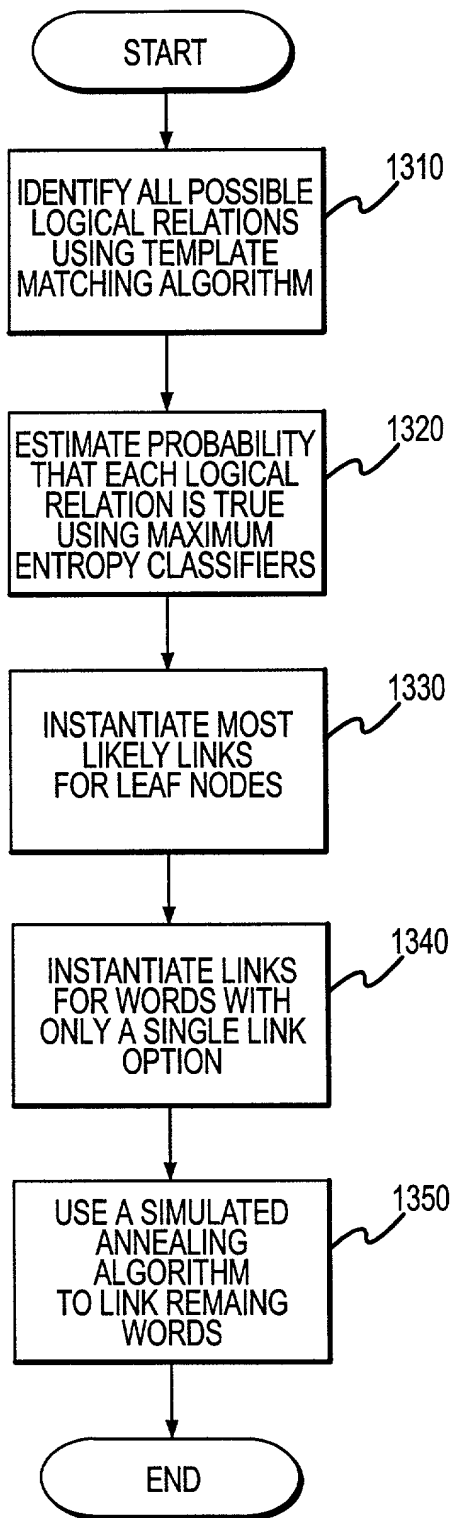
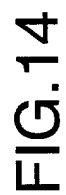


FIG.13

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NLP Finding

Entity ID: 'mass'

Entity Class: FINDING Abnormal.lesion

Existence

Currently

Attribute	Value
How Determined	by observation
Certainty of Existence	certain
Relevancy of Note	significant

Change (t2-Currently, t1=previous exam)

Attribute	Value
Direction of Change	stable, still exists
Magnitude of Change	no change in existence

Location

Spatial-Relation	Anatomy Description	Standardized Anatomy Description
'in'	right apex	apex of right upper lobe of lung

State

Current

Size

Dimension	Relation	Value	Units	Precision
Diameter	=	8	cm	Approximately

external architecture

Dimension	Relation	Value	Units	Precision
border definition	=	well demarcated	n/a	n/a

FIG.15